

Quality control is all about one thing: finding out what is wrong with your product, organisation, or service, and putting the wrong right. Some may argue that is an oversimplification, but oversimplifications can often get the point across. Eliminate the negative, and what's left is more positive. That's why we drive reliable cars that don't rust, because car makers learned these lessons.

Improving services is just the same. Spot a problem, and eradicate it, and the service must be better. That's even more apposite when the process of quality control includes defining what standards have to be met. Much of this issue of ImpAct is about improving services through quality control and quality improvement.

Tools not rules

People sometimes worry about quality control because it connotes rules. But quality control, or quality improvement is actually all about using tools to make the daily grind less of a grind, to make it more efficient, and to make it more satisfying. The EFQM Excellence Model®, developed by European Foundation for Quality Management (page 5), is particularly user-friendly.

There are some good tips here for those developing Primary Care Groups. We would argue that the EFQM Excellence Model® is an essential tool for them. There is more useful information on the EFQM Internet site at www.efqm.org/.

Don't hold back

ImpAct stories always give a contact person. This is someone who wants to pass on their experience, and share their enthusiasm for making things better.

Don't hold back. Call them, and get more information about how they have done it. If someone has done it, you can build on their experience and make a difference to your organisation as well.

In this issue

Developing colposcopy services	p. 1
Shared care for diabetes	p. 3
Proven approach to quality management	p. 5
Mothers control post Caesarean pain	p. 6
Cancer patients and carers fight it together	p. 7

*The views expressed in **Bandolier** are those of the authors, and are not necessarily those of the NHSE*

ACHIEVING REAL CHOICE FOR PATIENTS

Developing the colposcopy service in South Tees

Why was the initiative launched?

In 1996 a number of incidents in UK hospitals put the spotlight on the quality of cervical screening. Their reliability was questioned. In South Tees the service had achieved some Patients Charter standards, but the colposcopy team felt that a better service was possible from the resources available. Some improvements had been achieved, but the service was a bit of a Cinderella: management was concerned with larger issues. The team was determined to make their colposcopy service better.

What was done?

The Trust was already adopting the EFQM Excellence Model®. Three pilot projects in 1996 had shown that significant innovative change could be achieved. The colposcopy team and lead consultants, Mr Stewart Hutchison and Mr Derek Cruickshank, decided that the way forward was to apply the EFQM Excellence Model to colposcopy.

The team, including a local GP and every member of staff who had a role in colposcopy care within the Trust, developed a project plan. This had nine steps, using the EFQM model as a framework for the work. The first step (1) was to identify the scope of the work. The next steps helped them understand the service then provided, by:

2 Establishing a full picture of the service using a benchmarking approach. Benchmarking showed a service in need of care and attention. Some of the main points were:

- ◆ 13.5 days to generate an appointment.
- ◆ Long waiting times for initial and treatment appointments: 13 – 18 weeks.
- ◆ High rates (20%) of did not attends.
- ◆ Poorly organised, overbooked clinics.
- ◆ Delays of six to eight weeks from smear being reported and the GP referring the patient.
- ◆ Poor quality, confusing patient information.
- ◆ 35% of nursing time finding results and preparing notes.

3 Describing local processes: mapping how the service operated. Mapping was challenging because it demonstrated how little some people knew about the overall process. It enabled the team to understand its problems. The whole team identified the main steps, and small project groups produced detailed maps for the individual process steps.

4 Identifying what patients wanted from the service and the issues of concern to them. Patient focus groups contributed to fact-finding, ensuring that professionals were fully aware of the issues of concern to patients.

5 Designing the new service involved the whole team identifying the ideal requirements for the new service such as:

- ◆ Minimal waiting times for patients.
- ◆ Greater choice for patients.
- ◆ Improving communications to patients and GPs.
- ◆ Appointments generated from abnormal smear results.
- ◆ Reducing inappropriate care.
- ◆ A service improving on national standards.

The guidelines in *Standards and Quality in Colposcopy* from the NHS Cervical Screening Programme provided a basis for developing local standards. Three groups looking at pre-attendance administration and care, attendance and post attendance administration, and follow-up care undertook the redesign. Coherence between the separate stages was important to ensure that each activity added value to the overall service. Key features of the new service would be:

- ◆ Direct referral from cytology.
- ◆ Introduction of *see and treat*, that is, offering patients with severe abnormal smears treatment at their first visit and therefore eliminating a further clinic visit.
- ◆ Longer consultations for patients, supported by high quality information.
- ◆ Introduction of a default management strategy to ensure consistent action when patients failed to attend.
- ◆ Elimination of inappropriate referrals to the clinic.

6 Appraising the implications of the new service was important because some radical changes were required. A number of new roles had been defined to respond to frustration among team members, for example, providing an extended role for nurses to free doctors time.

One of the more radical proposals was to use abnormal smear results as a referral trigger and eliminate about eight weeks of delay out of the process. This challenged the traditional responsibilities of GPs so the team talked directly to all practices to convince them that this was the right way forward. GPs were content so long as monitoring systems were put in place.

7 Planning implementation focused on training to ensure that staff understood their roles in the new service. It was estimated that 40% less clinic time would be required, but at the same time providing twice as much time for each individual patient. The senior nurse, Sandra Knott, led the implementation stage of the project plan (8).

What has changed?

The redesigned service was implemented in June 1997 and the team put in place evaluation measures as the final part of their project plan (9). Any emerging problems can be identified and acted upon promptly. This involves regular team reviews and continuous audit, and discussion with primary care teams, the health authority and service users.

The evaluation has demonstrated dramatic improvement.

- ◆ Appointments generated in 24 hours not 13.5 days.
- ◆ Consultation time increased by 50%.
- ◆ Patient choice for *see and treat* service.
- ◆ After six months the rate of patient failing to attend appointments was reduced from 21% to 10%.
- ◆ Very high patient, GP and staff satisfaction.

Effects of EFQM Excellence Model applied to colposcopy services in South Tees

Activity or measure	Benchmark before review	Target	December 1997 6 months	June 1998 1 year	June 1999 2 years
Time from smear result being available and receipt of referral letter	6 weeks	To have direct referral from cytology within 24 hours of results being reported	24 hours	24 hours	24 hours
Time to generate appointment letter	13.5 days	3 working days	24 hours	24 hours	24 hours
Waiting time for new referrals	Maximum 18 weeks	Within 6 weeks with prioritisation system	13 weeks	7 weeks	7 weeks
Clinic defaulter rate	20%	10% in year 1 5% in year 3	12.60%	11.50%	10.70%
Consultation time	Average 10 minutes	30 minutes per patient	target achieved	target maintained	target maintained

Tips for success

- ✓ Don't expect a 'quick fix' – high quality services take time and energy to construct.
- ✓ Find a good leader – someone who can handle service design, staff development and advocacy for patients.
- ✓ Build on the creativity of professionals and patients: together they generate ideas and help, not hinder change.
- ✓ Be prepared for uncomfortable discussions: questioning traditional boundaries is difficult. Get help from someone trained to deal with change.
- ✓ Two (or more) heads are better than one: create teams which cross traditional boundaries.
- ✓ Remember that working across organisational boundaries is different: leadership is important

To find out more contact

Karen Picking
Senior Organisation Development Adviser
South Tees Acute Hospitals NHS Trust
Education Centre, South Cleveland Hospital
Marton Road, Middlesbrough TS4 3BW

Telephone 01642 854199 Fax 01642 282429

The following materials are available:

- ◆ Project report
- ◆ Patient focus groups reports (2)
- ◆ Patient satisfaction reports (2)
- ◆ GP satisfaction report.

ImpAct Bottom Line

⇒ Don't rest on the status quo - encourage innovative ideas and the potential of new roles as ways to improve service quality.

A MODEL OF CARE FOR PATIENTS WITH DIABETES

Creating effective shared care for patients with diabetes in Salford

Why was the initiative launched?

In 1994 Salford Royal Hospitals NHS Trust started to use the EFQM Excellence Model® as a framework for developing excellence in its services. The work by the Diabetes Clinical Team reflected their concern about co-ordination between primary and secondary care. Patients were complaining about delays in referral, about the information available and about the care provided in the community.

What happened?

The Diabetes Clinical Team agreed that the overall result required was an improvement in quality of care of patients across the primary/secondary divide. To be clinically effective care had to be multidisciplinary. In particular the team sought an increase in the percentage of diabetic patients having a structured preventative care review because this would increase early detection and treatment of potential complications of diabetes. The clinical result would be an increase the percentage of diabetic patients with total cholesterol below 5.5 mmol/L and LDL Cholesterol below 3.5 mmol/L, with a reduced diabetes complication rate.

Chosen approach

The approach chosen by the Diabetes Clinical Team was to promote 100% shared care. This required significant improvements in the quality of information available. Action was taken to build on a local diabetes register and create a district-wide diabetes information system.

The new system provides information about all aspects of patients' history and management. It builds on the princi-

ple that people putting information into an information system should get out more than they put in. The system prompts users to follow the district protocol for preventative care and to keep it updated. When patients are seen at hospital new information is added directly. When patients are seen in primary care, new information is sent by post, though systems to enable direct access for primary care are being explored. After new information has been added, an updated summary is sent to the GP **and to the patient**. GP's also receive quarterly summaries about their patients.

All patients in the district now have an annual nurse review. The review creates a contract between the nurse and the patient to ensure clarity about what patient needs to know and do. Problems occurring between reviews are referred directly to the specialist nurse for assessment. Patient education is a feature of all reviews provided in hospital. Non insulin dependent patients, whose reviews are undertaken in primary care, are offered educational sessions at the hospital.

Since the initiative was launched, communications and the development of good working relationships have been given priority. Care has been taken to ensure that messages have been consistent and the messenger heard. Peer links are encouraged, for example between nurses in secondary and primary care and between non-clinical staff (such as IT and practice managers). Regular sessions are arranged to allow staff from primary and secondary care to get together and discuss current issues: what have been the problems this month? The sessions are proving popular and attracting many GPs and practice nurses.

Resources deployed

The local Consultant, Dr Bob Young, led the initiative working with the Diabetes Clinical Team. Systems have been put in place to identify and deliver training to enable staff to

Trends in diabetes care in Salford

Key performance indicator	1993	1998
Number of Salford residents with diagnosed diabetes	4780	5352
Patients screened in last 18 months	55%	73%
Patients with total cholesterol <5.5 mmol/L	32%	74%
Patients with total LDL cholesterol < 3.5 mmol/L	15%	54%

Complications Rate	1995	1998
Diabetes-related amputations (knee)	9	4
Diabetes-related amputations (toes)	15	8

Complications Rate	UK	Salford
Blindness due to diabetes < 50 years	1- 4%	0.04%

play their part in the new service. Staff are encouraged to challenge current skill mixes. The use of Individual Performance Review (IPR) and Personal Development Plans (PDPs) have been given particular prominence. All hospital staff have IPRs and PDPs. This is being extended to primary care, with PDPs in place for practice nurses. The role of practice nurses in diabetes management is now reflected in a specific English Nursing Board course offered through the Diabetes Centre and accredited by Salford University.

Assessment and Review

A District Diabetes Steering Group has regular educational meetings and uses data from the district-wide diabetes information system to review practice. The shared-care guideline is continually updated to reflect findings of reviews of evidence undertaken by the multidisciplinary diabetes team. The local guideline places emphasis on enabling patients to get to the right part of the system at the right time.

Does it work?

Shared care for patient with diabetes in Salford was achieved, on time, by January 1998. Specific local service improvements were:

- ◆ Seamless care for patients, with strong links between primary and secondary care.
- ◆ Knowledgeable local GPs who understand diabetes management.
- ◆ Practice nurses who are confident about their role in the care of patients with diabetes.

- ◆ Diabetes specialist nurses in hospital providing consultation sessions for first referrals.
- ◆ There is a new role for non-clinical support assistants to work in hospital clinics.
- ◆ Patient awareness of the nature of local services and how to access them.

The Table illustrates the improved quality of service being provided. The improvements have been achieved within existing resources, but problems are emerging. For example, patients have direct access to the specialist (hospital-based) nurses: they can self-refer. Over 6,000 telephone questions have been asked of the four specialist nurses, and accommodating this within other clinical work is difficult.

The district-wide diabetes information system that supports the service has been a particular success and now allows rapid audits, virtually at a keystroke, to assess all aspects of care. It provides reliable monthly and quarterly analyses to allow monitoring of the service. This IT system is now in use in about 40 diabetes services in other UK hospitals.

Tips for success

- ✓ Define the results required before starting the initiative and involve patients and multidisciplinary teams.
- ✓ Put the development of information high on the agenda. Information is the key to a good service.
- ✓ Select the most appropriate approach to achieve the required results and agree a strategy.
- ✓ Assess staffing levels and ensure that local service managers are party to discussions. Don't leave them out and expect them to deliver increased budgets.
- ✓ Encourage all staff to play a part in staffing issues. Encourage the question "why do I need to do this?"
- ✓ Give patients information about local services and how to access them – but ensure that the service will be able to cope with demands.
- ✓ Systematically assess and review how effectively the chosen approaches are delivering the results required.

To find out more contact

Henry Stahr
Corporate Development Manager
Salford Royal Hospitals NHS Trust.
Stott Lane, Salford M6 8HD

Tel 0161 787 4212 Email hstahr@mcmail.com

The following materials are available:

- ◆ Local service guideline for shared care
- ◆ Broad specification for the IT system
- ◆ Patients handbook
- ◆ Examples of personal development plans

ImpAct bottom line

Using a recognised development model can ensure that effort and resources are used to the best effect.

A PROVEN APPROACH TO QUALITY MANAGEMENT

This issue of *ImpAct* features case studies from Salford and South Tees. Both chose to use the 'EFQM Excellence Model', developed by European Foundation for Quality Management between 1988 and 1991 to provide a structure for their work. The model offers a way of looking at the whole of an organisation's activities (Figure). It is not only about performance and outputs - but also about internal processes and the use of resources. All the organisations involved have found it a helpful way to manage the work.

Application of the model's assessment process ensures that an organisation can see where it is performing well and where it is performing poorly. This health check can spot important areas for improvement and provide a baseline for a cycle of continuous improvement starting with clearly defined results required by patients and clinicians. Once the results are agreed the most effective approaches can be designed and resources deployed. The effectiveness of the approaches chosen can then be assessed and reviewed.

Since the model looks at both the results achieved and the processes that produce them, it can identify good practice and offer predictions of performance. Extensive use of the model by a variety of public organisations has shown that it is fully applicable to the public sector.

As part of the Modernising Government initiative, the Cabinet Office has call off contracts with leading providers of EFQM Excellence Model services. These provide reduced rate training and consultancy for all public sector organisa-

tions, including those in the health service, wishing to use this model. A public sector database, operated by the Civil Service College, can store the results of EFQM Excellence Model assessments on a confidential basis. This information in summary form can be used to help organisations compare (or benchmark) their performance with others.

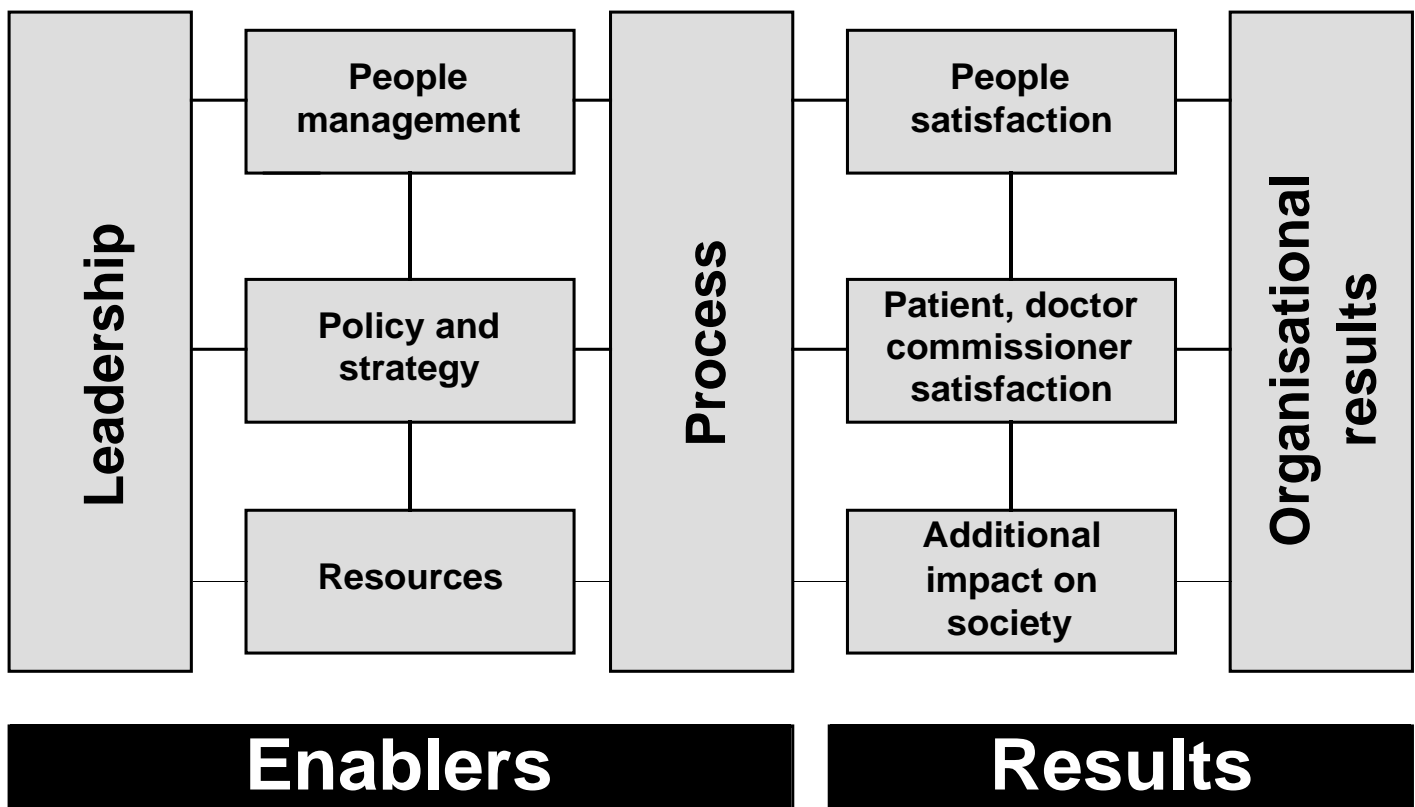
For more information contact

Paul Robinson
Cabinet Office
Effective Performance Division
Horse Guards Road
London SW1P 3AL
Telephone 0171 270 1951
Email probinson@cabinet-office.X.gsi.gov.uk

Mr Michael Perides
British Quality Foundation
32-34 Great Peter Street
London SW1P 2QX
Telephone 0171 654 5040
Email mike.perides@quality-foundation.co.uk

The European Foundation for Quality Management has a website at www.efqm.org/ that is well worth a visit. It has information on the Foundation, and especially its publication list, which is extensive, relevant, and inexpensive. It also has much additional information on the model.

EFQM model of excellence adapted to healthcare



DO-IT-YOURSELF PAIN CONTROL

Introducing self-medication for mothers after Caesarean section at Warwick Hospital

Why was the initiative launched?

The successful implementation of an acute pain service prompted questions about how pain control was managed for women after Caesarean section. Methods used there had evolved over time. Midwives and doctors thought it could be improved, but for different reasons, while no-one knew what mothers thought because they hadn't been asked.

What was done?

Two parallel paths of action were set in hand in 1996. One was a baseline audit to establish the nature of pain control being provided to mothers. The other was a review of the evidence about effective analgesic prescribing.

The audit involved case note review and interviews with 30 mothers in late 1996. Although mothers generally expressed satisfaction when asked, the audit suggested that pain control was not always satisfactory. Pain limited function, stopping some mothers from feeding and bathing their babies. Pain was not being routinely assessed.

The audit prompted the formulation of a local protocol for the management of post-Caesarean pain. From the review of evidence, an oral regime was adopted based on the Oxford league table and Chesterfield system. This three-step approach relied on the appropriate use of paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs) and oral morphine. Key features of the protocol were the introduction of formal pain assessments, the use of pre-printed prescription labels to apply to drug charts and the introduction of self-medication by mothers.

The self-medication aspect of the protocol became practical after the Trust was persuaded to change its policy for Oramorph. Previously the Trust had treated all concentrations of Oramorph as controlled drugs even though there was no legal requirement to treat low concentrations (10 mg/5 ml) in this way. Information obtained from the Department of Health, the Royal Pharmaceutical Society and the United Kingdom Central Council for Nursing and Midwifery (UKCC) helped to convince the Trust that deregulating Oramorph would be acceptable.

A local education programme was introduced by professionals from the Acute Pain Service by individual face-to-face sessions (doctor to doctor, nurse to nurse) rather than through seminars. This ensured that the process had minimal impact on clinical commitments. The tutorials were designed to reflect the likely concerns and anxieties of professionals. For example, midwives were being asked to move away from the traditional approach to the control of drugs to one which placed

responsibility on mothers. They would no longer be responsible for signing out drugs and needed to be assured of the legitimacy of the new approach.

The introduction of self-medication was supported by a patient information leaflet. Reflecting the three-step approach, the leaflet explained how mothers should handle mild, moderate and severe pain and how to seek advice if needed. These leaflets have a sell-by date ensuring they are kept up to date and are maximally helpful to mothers.

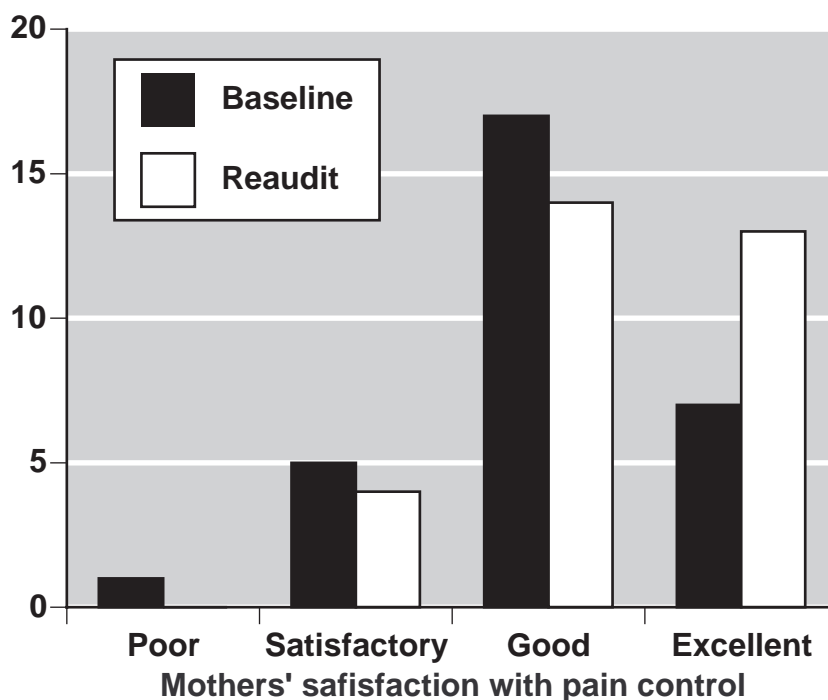
Is it working?

The new protocol was introduced in early 1997. The Acute Pain Service has monitored its implementation and ensured that any problems are tackled. The new approach has proved to be popular with mothers and is improving the management of pain. A re-audit in 31 mothers showed that:

- ◆ Maternal function was much improved. Only seven mothers were not caring for their babies with just one giving pain as the reason (the other six were in SCBU). In the baseline survey, the numbers were 13 and 10 respectively.
- ◆ The incidence of severe pain at rest and on movement was down by about 30%.
- ◆ Mothers were more satisfied with their pain control. Over 40% (13) rating pain control as excellent compared with about 20% (7) in the baseline.

The audit findings were encouraging in demonstrating progress, but it also helped to identify aspects of the care where further improvement could be achieved. For example, it identified that most pain was occurring as the regional anaesthetic wore off, before the self-administered analgesics were commenced. The first dose should be administered early enough to take effect before the spinal anaesthetic has worn off. The protocol has been revised to reflect this approach.

Number of Mothers



The length of stay of mothers was not recorded in the baseline audit but subsequent examination of hospital records revealed an encouraging reduction of one day between the baseline and re-audit. Based on the hospital's average number of Caesarean sections (438 a year), the average reduction of one postoperative day suggests a saving of about £95,000 per annum or 438 bed days. It could be argued that these savings are a direct consequence of the new protocol because there have been no other policy or operational changes in the care of mothers after Caesarean section.

Tips for success

- ✓ Encourage the view that mothers capable of looking after their babies should be able to manage their pain.
- ✓ Oral dosing is simple and effective. Complex techniques (like epidural infusions) restrict activity and delay mothers' return to normal function.
- ✓ Avoid relying on paper to convey information to clinicians because they may have little time to read them.
- ✓ Concentrate on providing face-to-face tutorials for clinical staff rather than trying to set up seminars.
- ✓ Do your homework and understand peoples' concerns. Don't expect everyone to react in the same way and allow for that.

- ✓ Choose the right messenger. Clinicians may listen to and heed the advice of their peers rather than someone from another discipline, however well informed.
- ✓ Be clear who has authority to make decisions that support or hinder your efforts. Get them on side.
- ✓ Develop your plans incrementally: build on successes.

To find out more contact

Dr Hugh Antrobus
Consultant Anaesthetist
Warwick Hospital
South Warwickshire General Hospitals NHS Trust
Lakin Road
Warwick CV34 5BW

Telephone 01926 495321 extension 4488
Email jhl.antrobus@virgin.net

The following materials are available

- ◆ Protocol for self-medication of postoperative analgesia
- ◆ Patient leaflet
- ◆ Adhesive prescription label for drug charts

ImpAct bottom lines

- ⇒ Make adopting change easy for clinicians: find ways to facilitate change, which do not unduly add pressure to clinical commitments.
- ⇒ Don't believe that complex solutions are bound to be the best – simple approaches can be effective

SKY DIVING NOT YET AVAILABLE!

Creating a FIT club: fight it together for cancer patients in Chirk in North Wales

Why was the initiative launched?

A problem for the Chirk locality management team in 1998 was the high incidence of patients with cancer and the heavy workload this was imposing on the staff of the hospital and community. Ways were needed to respond to this challenge whilst working within the resources available.

What was done?

A series of multi disciplinary discussions were arranged to explore how existing resources could be adapted to improve benefits to patients. These included hospital and community professionals, Macmillan nurses, potential users, relatives and carers. Two key points from the Calman Hine report guided them:

"The development of Cancer Care Services should be patient centred and should take account of patients, families and carers views and preferences as well as those involved in cancer care. Indi-

viduals' perceptions of their needs may differ from those of the professional. Good communications between professionals and patients is especially important in this area."

"The impact that diagnosis and treatment of cancer has on patients, families and their carers. Psychosocial aspects of cancer care should be considered at all stages."

The main conclusion from these discussions was the merit of providing a palliative day care service at the day hospital facilities at Chirk Hospital.

An important part of subsequent discussions to get the day centre established was a multidisciplinary and multi-agency meeting. The local Macmillan nurse played an important role in enabling patients to contribute to the discussions. Patients were in no doubt about what they wanted, and what they did not want. From the patients' perspective they needed a safe, friendly environment, to be listened to, to be treated with respect, to have the support of other patients and for the service to be both a drop-in centre and provide day care.

The group suggested the name for the centre the "FIT Club" - Fight It Together Chirk Cancer Club. People attending would be known as members irrespective of whether they were patients, carers or their children.

Fight it together - Activities

Coffee and a chat	Hairdressing
Horse riding	Information
Massage	Manicure
Painting	Relaxation
Reflexology	Swimming
Tai Chi	

Plus professional support for patients, carers and children from health visitors, specialist nurses, MacMillan nurses and nurses from hospital and community services.

While the initiative gained widespread support, there were initial apprehensions about the nature of the proposed approach. To help overcome these, managers arranged a series of educational and training events. Professionals were also encouraged to attend courses at the local hospice and other cancer specialist units. Greater knowledge led to more confidence that the new service could be provided and would help.

Is it working?

The FIT club first opened its doors on Wednesday 9th September 1998. It was a step into the unknown for staff and members. Although ambulance transport had been arranged, on day one most members used their own transport. They could not wait! The day was a first for some

FIT – fight it together

New members: September 1998 to March 1999

Patients	35
Carers	37
Children	14

Ages of members: March 1999

Ages	Numbers
0-16	14
17-40	18
41-60	23
61-80	29
80+	2

Attendance: September 1998 to March 1999

Members	824
Professional	73
Others	42

EDITORS

Michael Dunning

Andrew Moore

Pain Relief Unit
The Churchill, Oxford OX3 7LJ

Editorial office: 01865 226132

Editorial fax: 01865 226978

Email: andrew.moore@pru.ox.ac.uk
michaeldunning@hotmail.com

Internet: www.jr2.ox.ac.uk/Bandolier/ImpAct

staff. It was the first time they did not wear uniforms and the first time they had experienced this kind of service.

Soon after the club was established, the members decided that they needed a committee to run the club. It now publishes a regular newsletter to help spread the word - to give news about coming events and to include articles by members. The committee has been able to secure support from local businesses. A variety of activities are now available, but as the club leaflet says, "sky diving not yet available".

There is a feeling of elation about how well the club has developed. Professionals recognise that they have learnt much and hope to continue learning as the club develops. Carers and relatives have benefited from being able to talk to others in similar situations. As one carer said "This has greatly helped me to relax as a carer, and given me a really positive attitude to the situation". And as one patient said "I'd had half of my chemotherapy treatment by the time I first came to the club, so I was able to give reassurance to a fellow member who was just about to start her treatment".

Tips for success

- ✓ Recognise that change means learning new skills, so provide adequate training and space for staff.
- ✓ Don't be afraid of involving patients because professionals and patients have much to learn from each other.
- ✓ Don't be put off because of the scarcity of resources and be imaginative in finding ways to use existing resources better.

To find out more contact

Carole Davies
Hospital Manager
Chirk Community Hospital
Chirk
Wrexham LL14 5LN
Telephone 01691 772430
Fax 01691 772342

A leaflet about the FIT club is available

ImpAct Bottom line

⇒ Working with patients can be a learning process. Both professionals and patients learn from each other.